CONNECTICUT
CENTER
for sight

PATIENT INFORMATION UPDATE

Reason for this visit____

Phone #______________________Cell #_____________________Work #_____________________

Name of your current primary care physician _____________________________________

Do you have any allergies to medications? Yes No
If yes, please list____

Have your **parents/siblings/children** had glaucoma, diabetes, high blood pressure, heart disease?

Family member **Medical issue**

___________________________ ____

___________________________ ____

___________________________ ____

Do you have Glaucoma? Yes No Do you have Diabetes? Type I Type II No

Do you smoke? Yes No
If no, have you ever smoked and if so, when did you quit? ______________________________

Please update and list all MEDICATIONS you currently take (prescription & over the counter) **-OR-** if you already have a list please bring the list and this form with you to your appointment:_______________________________

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